Health Savings Account Application

Department in:

1 HSA OWNER INFORMATION

(Custodian's name, address, and phone number above)

NAME AND ADDRESS	HSA ACCOUNT NUMBER
	SOCIAL SECURITY NUMBER (SSN)
DAYTIME PHONE NUMBER / E-MAIL (OPTIONAL)	DATE OF BIRTH / GENDER: ☐ Male ☐ Female

Type of Health Insurance Plan Coverage (select one): ☐ Self-Only ☐ Family

2 CONTRIBUTION INFORMATION

A. ACCOUNT NUMBER	B. AMOUNT	C. CONTRIBUTION DATE	D. TAX YEAR
	$		

E. CONTRIBUTION TYPE (select one):

- ☐ Regular
- ☐ Rollover from a Health Savings Account
- ☐ Rollover from an Archer Medical Savings Account
- ☐ Catch-Up (age 55 or older and not enrolled in Medicare)
- ☐ Transfer from a Health Savings Account
- ☐ Transfer from an Archer Medical Savings Account

3 CONTRIBUTOR INFORMATION

Contributor Relationship to HSA Owner (select one): ☐ HSA Owner ☐ Employer ☐ Family Member ☐ Other _____

4 DESIGNATION OF BENEFICIARY

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my primary beneficiaries die before me, the contingent beneficiaries named below will receive my HSA assets. In the event a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata basis to the other beneficiaries that share the deceased beneficiary's classification as a primary or contingent beneficiary. If all of the beneficiaries die before me, my HSA assets will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries will share equally. If the percentage total for each beneficiary classification does not equal 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. This designation revokes and supercedes all earlier beneficiary designations which may apply to this HSA.

A. Primary Beneficiary

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TAXPAYER IDENTIFICATION NUMBER	RELATIONSHIP TO HSA OWNER
%			
%			
%			
Total 100%			

B. Contingent Beneficiary

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TAXPAYER IDENTIFICATION NUMBER	RELATIONSHIP TO HSA OWNER
%			
%			
%			
Total 100%			

5 SPOUSAL CONSENT

_____ (HSA Owner Initials) **I Am Married.** I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.

_____ (HSA Owner Initials) **I Am Not Married.** I understand that if I marry in the future, I must complete a new Designation of Beneficiary form, which includes the spousal consent documentation.

I am the spouse of the HSA owner. Because of the significant consequences associated with giving up my interest in the HSA, the custodian has not provided me with legal or tax advice, but has advised me to seek tax or legal advice. I acknowledge that I have received a fair and reasonable disclosure of the HSA owner's assets or property, including any financial obligations for a community property state. In the event I have a legal interest in the HSA assets, I hereby give to the HSA owner such interest in the assets held in this HSA and consent to the beneficiary designation set forth in Section 4 of this form.

✍X _____ Signature of Spouse Date

✍X _____ Signature of Witness (if required) Date

6 SIGNATURES

If this HSA is being established with a regular contribution, I certify that I am covered by a qualified high deductible health plan (HDHP), and that I am not covered by a health plan other than an HDHP that provides any of the same benefits as an HDHP. If this HSA is being established with a rollover or transfer contribution, I certify that the rollover or transfer assets are from another HSA or Archer Medical Savings Account (MSA). I certify that the information provided by me on this Application is accurate, and that I have received a copy of the Application, Health Savings Custodial Account, and Disclosure Statement. I agree to be bound by the terms and conditions found in the Application, Health Savings Custodial Account, Disclosure Statement, and amendments thereto. I assume sole responsibility for all consequences relating to my actions concerning this HSA. I understand that I may revoke this HSA on or before seven (7) days after the date of establishment. I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions.

✍X _____ Signature of HSA Owner Date

✍X _____ Signature of Custodian Date